Approaches to achieving universal coverage in health care: Summary of key points and action items.

International Health Financing Conference held by the « Centre d'Études et de Recherches sur le Développement International » (CERDI) in Clermont Ferrand, France, 1-2 December 2005

The Conference brought together a range of **researchers, policy makers and implementers** in the field of health financing, with a focus on developing and countries in transition. It provided opportunities for an open technical debate on the efficiency and applicability of new as well as old health financing mechanisms, focusing mainly on approaches to achieving **universal coverage in health care.**[1] Within this discussion, participants paid particular attention to issues surrounding user fees, health insurance, and the allocations of public budgets with a focus on priority health interventions.[2] While it is worth emphasizing that **universal coverage is achieved through step-by-step improvements in coverage**, some of the determinants of the speed and mode of transition to universal coverage include sustained economic growth, a growing workforce in formal employment, the existence of trade unions, the availability of skilled personnel, the degree of solidarity in society, and government stewardship. For instance, it has taken the Philippines three decades to achieve near universal coverage through its model of social health insurance. Some of the major thematic areas of presentation and debate are captured below.

Despite the attention currently being paid to the abolition of **user fees** for primary (and in some cases secondary) health services, the general opinion at the conference was that there exists **no global blueprint for health financing policy**. Although there is consensus that user fees are an inefficient and regressive form of health care financing, they are, in many instances, still seen as 'a necessary evil'.[3] The best health financing mix needs to be assessed for each national and sub-national context. While good examples of user fee abolition were presented (e.g. Uganda), there are also cases where user fee abolition did not have only positive effects (e.g. Kenya, Madagascar). In most of these cases, however, there exists a huge unmet population need for health services, as illustrated by the surge in demand after removal of user fees. In contrast, **prepayment** mechanisms offer a more equitable and ultimately more efficient way of financing health care, as opposed to collection of revenues at the point of service delivery. In the absence of such mechanisms, research shows that populations prefer to pay user fees in exchange for quality services rather than to receive free but poor quality services.

Health insurance, for its part, represents an important potential for moving towards universal health care coverage, including in low-income settings.[4] Some studies reveal that the selected insurance model must be carefully evaluated based on contextual factors. For example, health

[1] WHO defines universal coverage generally as "access to appropriate care when it is needed and at affordable cost". The main functions relating to health care financing for universal coverage include revenue collection, pooling of resources, and health service purchasing.

[2] Other themes also featured in the presentations and debate, such as how to enhance provider performance through improved systems of governance and salary supplement schemes.

[3] This was the position of the World Bank in the 2004 World Development Report 'Making Services Work for Poor People', where it stated its position: *no blanket policy on user fees*.

[4] Note that a precondition of health insurance is that there exists a fee for health services: only if health services are charged for does there provide a financial incentive to take out health insurance.

insurance organized at the community level and supplemented with public funds is more appropriate for low-income populations and the informal sector, as it potentially provides access at low cost to major unserved parts of the population. In contrast, as incomes rise and more people are employed in the formal sector, other models of health insurance become relevant, such as social, national and/or private health insurances. Additionally, the coexistence of multiple insurance schemes can increase **administrative costs and burden**, especially at lower level facilities where capacity is limited.

The **financial viability of community health insurance** (CHI) received special attention in the presentations and debate. CHI suffers the problems of all voluntary insurance schemes – those of adverse selection and moral hazard[5], although empirical evidence on the former is stronger than on the latter. CHI schemes are financially risky, given the low premium rates that must be set to encourage poor people to insure themselves, and the fact that people tend to join only if they expect to gain financially from membership (in other words, adverse selection). This explains why many CHI schemes in low-income countries are made financially viable only through the availability of resource inputs (subsidies) from either donors or governments. Over the long term, as incomes gradually increase, so does the financial viability of insurance schemes. Moreover, once populations become familiar with insuring their health, it makes it easier to move to other models of health insurance.

Concerning **donor financing**, opinions differ as to whether it should be viewed as sustainable in heavily aid-dependent countries. While some delegates cited examples of poor predictability and stability of donor funds compared to other forms of health financing, other delegates showed how donor financing stability is on the rise and conditionality / earmarking on the decline. The advent of new donors and donation mechanisms has increased funds available, which are now also being pledged for longer time periods. For countries where aid modalities are more 'advanced' (e.g. sector-wide approach), the advent of global health initiatives has brought valuable additional resources but has challenged existing coordination mechanisms (e.g. Tanzania, Uganda). Further, researchers claim that Global health initiatives have had a negative effect on governance as resources generally remain outside government control and the new fund flow distorts resource allocation preferences of the recipient countries; furthermore, current resource allocations do not capture well some important health issues, such as reproductive health.

Can the ideas generated at this conference resolve some of the problems of health financing, provider motivation and quality of care? What schemes are worthy of greater study or even increased scale-up? For answers to these questions and more, visit www.research-matters.net and download Dr. Hutton's full paper on the subject of the Clermont-Ferrand conference.

[5] Adverse selection: people are more likely to take out insurance if they consider it likely they will use the services, and thus make a net gain. Moral hazard: once people are insured, they are more likely to use the service, hence pushing up health care costs, and the insurance premium that is needed to pay for the costs.